



SOUTH DAKOTA BOARD OF NURSING
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.nursing.sd.gov

Registered Nurse & Licensed Practical Nurse License Renewal

Licensure renewal information and fees must be received by the South Dakota Board of Nursing office *by your license expiration date* or your license will lapse. **It is illegal to practice nursing in South Dakota without an active nursing license.** You are responsible to maintain licensure whether or not you receive a renewal notice.

You may choose to renew your license by one of these two options:

Complete online renewal process at www.nursing.sd.gov – OR – Submit renewal paper application forms.

**Individuals with previous disciplinary actions or criminal convictions must submit the paper application forms.*

Option 1. Complete Online Log on to the South Dakota Board of Nursing web site, www.nursing.sd.gov

- Select Online License Renewal on the South Dakota Board of Nursing website,
- If you are a first time user, you must register. To register, provide a “user name” and create a password for yourself. *Please remember*, when you return to the Online License Renewal page for future use, you will be asked to enter your “user name” and password. As such, keep your login information and secure it in a safe place.
- Once logged on, you will be able to select the option to renew your license. Enter information as requested. Please be advised:
 - When entering information, do NOT use commas or decimal points. Enter all employment hours in whole numbers, for example 1250 will be accepted, but 1,250 or 1250.0 will NOT be accepted.
 - Verification of Employment as Nurse: You will be required to attest to the hours that you have worked during this renewal period. The board will periodically audit nurses and will request a completed Employment Verification Form; therefore maintain the completed form in your personal files.
 - Address Changes: Once you have completed entering your new address information **exit** or log out of the site, then log back in and complete the renewal. If you do not exit your zip code verification for your credit card billing address may fail.
- **Fee: \$90.** Online payment must be made with a **VISA or MASTERCARD only**. All other payment options will require you to submit the paper application forms.
 - Make certain your billing address and zip code match your license address and zip code.

Contact the South Dakota Board of Nursing if you have any questions.

Option 2. Submit paper application. Please follow instructions carefully to avoid delays in processing your renewal. If any information is incorrect, incomplete or illegible, processing may be delayed. Upon receipt of all forms and fees at the South Dakota Board of Nursing office your application will be considered for renewal. You will be notified if additional information is required.

To RENEW your nursing license, **submit the following** to the South Dakota Board of Nursing office:

- Completed Application for RN/LPN License Renewal Form
- Completed Employment Verification Form
- **Fee: \$90**
 - Payment should be in the form of a money order or a personal check payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany form. A \$20 fee will be charged for any insufficient check written.
 - Credit card payment cannot be accepted with this option of renewal.

Application for Registered Nurse & Licensed Practical Nurse License Renewal

I request to RENEW each license checked: ☐ SD RN: License #(s): _____
☐ SD LPN: License #(s): _____

(Please Print)
 Name: First _____ Middle _____ Last _____

Address: _____
 Street/PO Box _____ City _____ State _____ Zip _____

Telephone: Home: (____) _____ Other: (____) _____ Email: _____

Date of Birth _____ Telephone: Home: (____) _____ Other: (____) _____

Declaration of Primary State of Residence

I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is:

_____. This is my "home state" under the [Nurse Licensure Compact](#) and is my "declared fixed permanent and principal home for legal purposes."

– OR –

I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: _____

RN License # in primary state of residence if other than South Dakota: _____

Disciplinary Information

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.	<input type="checkbox"/> YES	<input type="checkbox"/> No
2.	Is there any pending criminal prosecution against you which would constitute a felony?	<input type="checkbox"/> YES	<input type="checkbox"/> No
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	<input type="checkbox"/> YES	<input type="checkbox"/> No
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	<input type="checkbox"/> YES	<input type="checkbox"/> No
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	<input type="checkbox"/> YES	<input type="checkbox"/> No
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	<input type="checkbox"/> YES	<input type="checkbox"/> No
7.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	<input type="checkbox"/> YES	<input type="checkbox"/> No
8.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	<input type="checkbox"/> YES	<input type="checkbox"/> No
9.	Do you currently owe child support arrearages in the sum of \$1,000 or more?	<input type="checkbox"/> YES	<input type="checkbox"/> No

For 2-9 above, provide an explanation for each Yes response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.

Continues

Employment Information: Select **ONE** response in each category below that best represents your current practice.

Employment Status: <input type="checkbox"/> Full-time Nurse <input type="checkbox"/> Part-time Nurse <input type="checkbox"/> Full-time other than Nursing <input type="checkbox"/> Part-time other than Nursing <input type="checkbox"/> Volunteer Nurse <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	Where Presently Employed: County: State: City: Zip Code:	Type of Position: <input type="checkbox"/> Nurse Management <input type="checkbox"/> Consultant <input type="checkbox"/> Case Manager <input type="checkbox"/> Nursing Program Faculty <input type="checkbox"/> Clinic Nurse <input type="checkbox"/> Staff Nurse <input type="checkbox"/> Charge Nurse <input type="checkbox"/> Inservice Educator/Staff Development <input type="checkbox"/> Advanced Practice Nurse <input type="checkbox"/> CNM <input type="checkbox"/> CNP <input type="checkbox"/> CRNA <input type="checkbox"/> CNS <input type="checkbox"/> Other
	Highest Degree Held: <input type="checkbox"/> Diploma / Registered Nurse <input type="checkbox"/> Associate Degree/RN <input type="checkbox"/> Baccalaureate Degree/RN <input type="checkbox"/> Baccalaureate in other field <input type="checkbox"/> Masters in Nursing <input type="checkbox"/> Masters in other field <input type="checkbox"/> Doctorate (PhD, Ed, DNP) <input type="checkbox"/> Practical Nurse Diploma/A.D.	
Principle Field/Place of Employment: <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home/Long Term Care <input type="checkbox"/> Nursing Education Program <input type="checkbox"/> Home Health / Hospice <input type="checkbox"/> School <input type="checkbox"/> Outpatient Surgical Center <input type="checkbox"/> Office / Clinic <input type="checkbox"/> Community Health <input type="checkbox"/> Self-Employed <input type="checkbox"/> Other	Formal Education Activities: <input type="checkbox"/> I am NOT taking courses toward an advanced degree in nursing <input type="checkbox"/> I am currently taking courses toward an advanced degree in nursing	

What percent of your current position involves direct patient care?

☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do you intend to leave/retire from nursing practice in the next 5 years? ☐ YES ☐ NO

States other than South Dakota in which you are licensed as a nurse:

Affidavit

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature of Applicant _____ **Date** _____



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VERIFICATION OF EMPLOYMENT

Applicant: Complete the top section of this form then forward to your employer or former employer. This form may be duplicated for additional employment verifications. Return completed form(s) to the South Dakota Board of Nursing.

To obtain/retain active licensure, a nurse must provide verification of a minimum of 140 hours in a 12-month period OR 480 hours in six years of employment/volunteer work in nursing.

Please Print

Name, First _____ Middle _____ Last _____

☐ I have been employed / volunteered as a nurse (LPN, RN, CRNA, CNM, CNP, or CNS).

☐ I have not been employed as a nurse within the last six years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

Signature of Applicant _____

Date _____

**This Section to be Completed by Employer
(Provide Employment Hours Within the Last 6 Years)
Note: This section Cannot be Signed by the Applicant**

The above-named individual (was) employed/volunteered as a nurse

From _____
Month/Date/Year

To _____
Month/Date/Year

Total hours worked in this period: _____

I the undersigned declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purpose of licensure is true and correct.

Signature of Agency Representative/Title _____

Date _____

Who can verify/confirm number of hours employed/volunteered

Name of Employer: _____

Address of Employer: _____

Telephone: _____ Email: _____